

Maine Revised Statutes
Title 24-A: MAINE INSURANCE CODE
Chapter 56-A: HEALTH PLAN IMPROVEMENT
ACT HEADING: PL 1997, c. 792, §2 (rpr)

§4317. PHARMACY PROVIDERS

1. Contracts with pharmacy providers. Notwithstanding section 2672, section 4307, subsection 3 and Title 32, chapter 117, subchapter 8, a carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers.

This subsection may not be construed to limit a carrier's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the carrier makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

[2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

2. Prompt payment of claims. Notwithstanding section 2436, the following provisions apply to the payment of claims submitted to a carrier by a pharmacy provider.

A. For purposes of this subsection, the following terms have the following meanings.

(1) "Applicable number of calendar days" means:

- (a) With respect to claims submitted electronically, 21 days; and
- (b) With respect to claims submitted otherwise, 30 days.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

B. A contract entered into by a carrier with a pharmacy provider with respect to a prescription drug plan offered by a carrier must provide that payment is issued, mailed or otherwise transmitted with respect to all clean claims submitted by a pharmacy provider, other than a pharmacy that dispenses drugs by mail order only or a pharmacy located in, or under contract with, a long-term care facility, within the applicable number of calendar days after the date on which the claim is received. For purposes of this subsection, a claim is considered to have been received:

- (1) With respect to claims submitted electronically, on the date on which the claim is transferred; and
- (2) With respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission of the claim. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

C. If payment is not issued, mailed or otherwise transmitted by the carrier within the applicable number of calendar days after a clean claim is received, the carrier shall pay interest to the pharmacy provider at the rate of 18% per annum. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

D. A claim is considered to be a clean claim if the carrier involved does not provide notice to the pharmacy provider of any deficiency in the claim within 10 days after the date on which an electronically submitted claim is received or within 15 days after the date on which a claim submitted otherwise is received. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

E. If a carrier determines that a submitted claim is not a clean claim, the carrier shall immediately notify the pharmacy provider of the determination. The notice must specify all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim. If a pharmacy provider receives notice from a carrier that a claim has been determined to not be a clean claim, the pharmacy provider shall take steps to correct that claim and then resubmit the claim to the carrier for payment. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

F. A claim resubmitted to a carrier with additional information pursuant to paragraph E is considered to be a clean claim if the carrier does not provide notice to the pharmacy provider of any defect or impropriety in the claim within 10 days of the date on which additional information is received if the claim is resubmitted electronically or within 15 days of the date on which additional information is received if the claim is resubmitted otherwise. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

G. A claim submitted to a carrier that is not paid by the carrier or contested by the plan sponsor within the applicable number of calendar days after the date on which the claim is received by the carrier is considered to be a clean claim and must be paid by the carrier. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

H. Payment of a clean claim under this subsection is considered to have been made on the date on which the payment is transferred with respect to claims paid electronically and on the date on which the payment is submitted to the United States Postal Service or common carrier for delivery with respect to claims paid otherwise. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

I. A carrier shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy provider so requests or has so requested previously. In the case when the payment is made electronically, remittance may be made by the carrier electronically. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

[2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

3. Exception. Subsections 1 and 2 do not apply to any medical assistance or public health programs administered by the Department of Health and Human Services, including, but not limited to, the Medicaid program and the elderly low-cost drug program under Title 22, section 254-D.

[2011, c. 443, §5 (AMD) .]

4. Participation in contracts . A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one network in order to participate in another network. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in one network solely because the pharmacist or pharmacy declined to participate in another network managed by the pharmacy benefits manager.

[2011, c. 443, §6 (NEW) .]

5. Prohibition. The written contract between a carrier and a pharmacy benefits manager may not provide that the pharmacist or pharmacy is responsible for the actions of the insurer or a pharmacy benefits manager.

[2011, c. 443, §6 (NEW) .]

6. Pharmacy benefits manager duties. All contracts must provide that, when the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager shall distribute the funds in accordance with the time frames provided in this subchapter.

[2011, c. 691, Pt. A, §23 (AMD) .]

7. Complaints, grievances and appeals. A pharmacy benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy solely as a result of the pharmacist's or pharmacy's filing of a complaint, grievance or appeal. This subsection is not intended to restrict the pharmacy's and pharmacy benefits manager's ability to enter into agreements that allow for mutual termination without cause.

[2011, c. 443, §6 (NEW) .]

8. Denial or limitation of benefits. A pharmacy's benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy for expressing disagreement with a carrier's decision to deny or limit benefits to an enrollee or because the pharmacist or pharmacy assists the enrollee to seek reconsideration of the carrier's decision or because the pharmacist or pharmacy discusses alternative medications.

[2011, c. 443, §6 (NEW) .]

9. Written notice required. At least 60 days before a pharmacy's benefits manager terminates a pharmacy's or pharmacist's participation in the pharmacy benefits manager's plan or network, the pharmacy benefits manager shall give the pharmacy or pharmacist a written explanation of the reason for the termination, unless the termination is based on:

A. The loss of the pharmacy's license or the pharmacist's license to practice pharmacy or cancellation of professional liability insurance; or [2011, c. 443, §6 (NEW) .]

B. A finding of fraud. [2011, c. 443, §6 (NEW) .]

At least 60 days before a pharmacy or pharmacist terminates its participation in a pharmacy benefits manager's plan or network, the pharmacy or pharmacist shall give the pharmacy benefits manager a written explanation of the reason for the termination.

[2011, c. 443, §6 (NEW) .]

10. Audits. Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria.

A. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, unless the projected overpayment or denial is a part of a settlement agreed to by the pharmacy or pharmacist. [2011, c. 443, §6 (NEW) .]

B. The auditor may not use extrapolation in calculating recoupments or penalties. [2011, c. 443, §6 (NEW) .]

C. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist. [2011, c. 443, §6 (NEW) .]

D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity. [2011, c. 443, §6 (NEW) .]

E. This subsection does not apply to any audit, review or investigation that is initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse. [2011, c. 443, §6 (NEW) .]

F. Prior to an audit, the entity conducting an audit shall give the pharmacy 10 days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit. [2013, c. 71, §1 (NEW).]

G. A pharmacy has the right to request mediation by a private mediator, agreed upon by the pharmacy and the pharmacy benefits manager, to resolve any disagreements. A request for mediation does not waive any existing rights of appeal available to a pharmacy under this subsection or subsection 11. [2013, c. 71, §1 (NEW).]

H. The requirements of section 4303, subsection 10 apply to claims audited under this subsection. [2013, c. 71, §1 (NEW).]

[2013, c. 71, §1 (AMD) .]

11. Audit information and reports. A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit under subsection 10. A pharmacy must be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeal process provided by the pharmacy benefits manager has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity.

§4317. Prohibition against maximum aggregate benefit provisions

(As enacted by PL 2009, c. 588, §1 and affected by §3 is REALLOCATED TO TITLE 24-A, SECTION 4318)

[2011, c. 443, §6 (NEW) .]

SECTION HISTORY

RR 2009, c. 2, §70 (RAL). 2009, c. 519, §1 (NEW). 2009, c. 519, §2 (AFF). 2009, c. 588, §1 (NEW). 2009, c. 588, §3 (AFF). 2011, c. 443, §§5, 6 (AMD). 2011, c. 691, Pt. A, §23 (AMD). 2013, c. 71, §1 (AMD).

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